ERGONOMIC EVALUATION

Name: **Date:** **Bldg:** **Rm:**

Sex: **Phone No:** **Payroll No:** **L-Code:**

Job Title:

Employer:

Supervisor: **Phone:** **L-Code:** **Notified?**

Evaluation Requested By: ☐ Supervisor ☐ Employee ☐ Medical

Reason for Evaluation: ○ Preventive ○ Reactive **SAAR Number:**

ITEMS CHECKED/ADJUSTED:

Chair/Model	
Footrest	
Worksurface	
Monitor/Glare Screen	
Keyboard/Wristrest	
Mouse/Trackball	
Copy Holder	
Lighting	
Vision	
Telephone	
Comfort Level	
Breaks Exercise	
Comments	

ERGONOMIC EVALUATION

RECOMMENDATIONS:

ITEM	DESCRIPTION	PART NO.	COST
Chair			
Footrest			
Wristrest			
Keyboard Tray			
Glare Screen			
Copy Holder			
Headset			
Other			
Other #1			
Other #2			
Other #3			
		TOTAL COST	

Work Surface

Lighting

Vision

Breaks/Exercise

Comments

Evaluator **Phone No.** **L-Code**

cc: Ergonomics File

GEN0000